DOCUMENT RESUME

ED 289 154 CG 020 421

AUTHOR Cornell, Dewey G.
TITLE Clinical Assessment of the Violent Adolescent.
PUB DATE 6 Mar 87
NOTE 18p.; Paper presented at the Annual Meeting of the National Association of School Psychologists (19th, New Orleans, LA, March 4-8, 1987). For related document, see CG 020 420.
PUB TYPE Information Analyses (070) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adjustment (to Environment); *Adolescents; Delinquency; Elementary Secondary Education; Evaluation Methods; *Personality Traits; *Predictor Variables; *School Counselors; *Violence

ABSTRACT

School psychologists may be asked to assess potentially violent adolescents. Research on predicting violence has demonstrated that: (1) most studies show poor predictive ability; (2) clinicians tend to overpredict violence; (3) prediction is difficult because the base rate is low; and (4) the best single predictor is past violent behavior. New perspectives on predicting violence suggest that aggressiveness is surprisingly stable over time, that long-term risk is not the same as imminent danger, that situational factors must be assessed, and that there may be multiple developmental pathways to violence. A study of 72 adolescents who had committed homicide revealed important differences in the backgrounds of nonpsychotic, violent adolescents. One group, who committed violent acts in the course of other criminal activity, had a history of juvenile delinquency, school problems, and substance abuse. Another group, who committed violent acts in reaction to interpersonal conflict, were relatively well-adjusted in comparison to the crime group. They tended to have school and community adjustment problems, although they appeared to be experiencing more environmental stress at the time of their violent behavior. In assessing potentially violent adolescents, counselors should review the purpose for the assessment with the adolescent, focus on recent violent behavior, assess situational factors, plan a course of action and discuss it with the adolescent, and follow through with appropriate action after the evaluation. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED289154

CLINICAL ASSESSMENT OF THE VIOLENT ADOLESCENT

Dewey G. Cornell
Assistant Professor

Institute of Clinical Psychology
Curry School of Education
University of Virginia

CG 020421

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Dewey G Cornell

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Presented at the 19th Annual Convention of the National Association of School Psychologists (NASP); New Orleans, Louisiana; March 6, 1987. A more detailed report of research findings contained in this presentation is available from the author. 405 Emmet Street. Ruffner Hall, Charlottesvile, Va 22903-2495.

CLINICAL ASSESSMENT OF THE VIOLENT ADOLESCENT

School psychologists may be asked to assess potentially violent adolescents for many different reasons. An adolescent may be getting into fights, he may have threatened someone, or he may be found carrying a weapon. Our evaluation of how potentially violent or dangerous an adolescent is may be critical - we may offer recommendations as to whether a youth needs counseling, should be removed from the classroom, or even removed from school and placed in a residential facility. In some cases we may need to decide whether to take immediate action - such as warning potential victims or pursuing hospitalization.

Today I want to discuss some of the major issues in research on adolescent violence, and then try to apply them to clinical assessment. What does current research tell us or not tell us about violent behavior in adolescence? How can we better conceptualize violent behavior in a way that helps improve our assessment procedures and our clinical decision-making?

I will be reviewing research on the clinical prediction of violence and then I will present some of my own research on juvenile homicide.

Clinical Prediction of Violence

One of the newest and best-known cliches in psychology is that "psychologists cannot predict dangerousness." This is a widely accepted negative finding from a brief series of research studies which tried to assess how well mental health professionals could

predict who would or would not become violent in the future.

Rarely has any negative finding in psychology been so quickly accepted and so widely repeated. However, this statement is not so much a reflection of our professional humility - it is a reaction to the heavy responsibility placed on psychologists when we are asked to make these kinds of predictions. Courts have held psychologists and other professionals responsible when they have failed to predict dangerousness by their patients - for example, when they have failed to warn potential victims and the patients have gone on to attack or even kill their victims.

We are quick to claim that we should not be held responsible for something we cannot do - yet at the same time we continue to do it in many clinical situations.

But, to be fair, anytime we evaluate someone who might be violent, it is impossible not to be concerned with prediction. After all, we are always concerned with the future and whether the adolescent might be violent again. The more concerned we are about future violence the more likely we will recommend serious intervention - such as a change in school placement. So, even when we are not making formal predictions for the court, we may be making implicit predictions that guide our educational and treatment recommendations.

If predictions are inevitable, what then can we learn from the clinical prediction research? The best work on this subject is John Monahan's book, Predicting Violent Behavior. I want to summarize 4 main points:

SLIDE ONE

RESEARCH ON PREDICTING VIOLENCE

1. Most studies show very poor predictive ability.
2. Clinicians tend to overpredict violence.
3. Prediction is difficult because the base rate is low.
4. The best single predictor is past violent behavior.

1) Most studies find that clinicians who predict someone will be violent are wrong more often than they are right. In one of the best studies (Steadman and Halfon, 1971) clinicians were wrong twice as often as they were correct when they predicted someone would be violent. If any of you today hoped I would be able to tell you how to predict violence, you will be disappointed.

A California study (Wenk, 1972) examined over 4,000 delinquents who were being released from detention. The study failed to predict who would end up back in detention within 15 months, even though it used over 100 variables.

2) One of the most common errors that clinicians make is to over-predict violence. Many more persons are predicted to be violent than who actually behave violently later on. Actually, there may be no satisfactory way to avoid this error. Clinicians may over-predict violence in order to err on the side of caution, in order to avoid overlooking someone who does become violent (Monahan, 1981).

3) One of the major reasons it is so hard to predict violence is that violent behavior is usually very rare. Even the most violent adolescent is not violent most of the time. This is an example of the

so-called "base rate problem" in which statistically it is extremely difficult to predict events that rarely occur (Meehl, 1973). If we always predicted that no one would be violent, we would be right the overwhelming majority of the time. Unfortunately, even one violent act is too many, so we have the Herculean task of trying to predict something very important, but very infrequent.

4) Finally, it is worth noting that the most important predictor of future violence which does work is past violence. If you are assessing a potentially violent adolescent, always, always, gather information about past violence. The more violent a person has been in the past, the more likely they will be in the future. This is especially true for adolescents and young adults. If you could use only one piece of information about an adolescent, history of past violence would be what you wanted to know.

New Perspectives

All of this may sound like gloomy news, another failure in modern psychology. However, there are some indications that all is not lost, and that these is some reason still to be hopeful about the possibility for accurate clinical prediction.

SLIDE TWO

NEW PERSPECTIVES ON PREDICTING VIOLENCE

1. Aggressiveness is surprisingly stable over time.
2. Long-term risk is not the same as imminent danger.
3. Situational factors must be assessed.
4. There may be multiple developmental pathways to violence.

1) Longitudinal research has demonstrated the stability of aggression over time. Children who are aggressive at an early age continue to be aggressive throughout childhood, adolescence, and into early adulthood. The results are really quite impressive. Dan Olweus reviewed 16 studies in 1979, and more recent research (Moskowitz, Schwartzman, & Ledingham, 1985) continues to support his analysis.

If you identify the most aggressive children in a classroom or peer group, then re-evaluate in several months or a year, those same children are still the most aggressive in the group. Correlations between aggressiveness at time 1 and time 2 ranged from the 50's to 80's for periods up to 1 year, and were still in the 30's to 50's after ten years. These findings held up when aggressiveness was measured by peer reports, teacher ratings, and by direct observation. Aggression appears to be relatively stable even when assessed in children as young as 3 and 4 years old.

2) Many of the studies in the prediction of dangerousness literature are not fully relevant to many clinical circumstances. After the widespread acceptance of the finding that we cannot predict violence, there has been a backlash in which critics have pointed out the limitations of the studies reporting such negative results.

The most common types of studies involve deciding whether or not to release someone from prison or a hospital. Clearly this kind of decision is not the same kind of clinical decision you make in evaluating whether someone should be sent to a prison or a hospital, or even whether they need treatment or special ed placement. Yet there has been a tendency to assume that if we cannot make one kind

of prediction, we cannot make any predictions.

The most important distinction here is between predictions of long-term risk versus predictions of imminent danger. When we decide whether or not to release an adolescent from detention, we are not just predicting what will happen next week, but every week far into the future. It's no wonder we have not been very successful at this.

In contrast, our short-term predictions focus on the question of imminent dangerousness. What action do we need to take now to prevent violence in the immediate future? In these circumstances we can assess how angry the adolescent is and who he's angry at. We can find out what his intentions are and what kind of stresses he is under right now (Keith, 1984). None of this is available in the long-term studies reported in the literature.

(Optional - There is very little research on how well we do at short-term, imminent danger predictions. One very recent study by McNiel and Binder (in press) examined patients who were committed to a psychiatric hospital. The patients who were committed because they were predicted to be dangerous to others were compared to patients who were committed for other reasons (danger to self or gravely disabled). Two-thirds of the patients who were predicted to be dangerous to others engaged in assaultive behavior within 72 hours of their admission to the hospital. In contrast, less than one-third of the patients not predicted to be dangerous were assaultive. This kind of finding suggests that short-term predictions may be possible.)

3) Everyone recognizes that violence is not just the result of individual factors, it's also the result of provocative situations

that elicit a violent response. When we predict someone is violent, we usually mean that they have the potential to be violent, given the right situation. In order to accurately predict violence, we have to know what situations they will encounter in the future as well.

Unfortunately, our training usually biases us to look at personality factors within the individual and we have few ways even to conceptualize, much less measure, the environment in a meaningful way. In assessing violent adolescents, we need to consider situational factors such as the adolescent's family environment and degree of adult supervision. We need to consider whether there is peer group support for violent behavior. Small details may be important, such as whether the adolescent has access to weapons. Is there a gun in the family home or does the adolescent carry a knife? The difference between an adolescent who shouts obscenities and one who attacks his victim may be whether or not there is a weapon handy when he loses his temper.

4) Is there such a thing as the violent adolescent? (Like my title suggests!) Violence is a social construct, a category we create which lumps together many different acts of physical aggression we disapprove of. When we switch from the language of everyday society to the language of science we use the same broad category. This may mislead us into assuming that violent behavior is the product of a single set of factors or that violent individuals are a homogeneous group. When we set up studies which compare violent adolescents with nonviolent comparison groups, we imply that the violent adolescents should all have something in common.

Research on Juvenile Homicide

To illustrate the importance of recognizing that there are important differences among violent adolescents, I want to review some research my colleague Elissa Benedek and I have conducted with adolescent murderers (Cornell, Benedek, & Benedek, 1987). We studied 72 adolescents (ages 12 to 18) who committed murder in Michigan and who were sent by the court for a pre-trial psychiatric evaluation.

Here is some descriptive information on these youth.

SLIDE THREE

(Age, Race, SES, Parent marriage, Abuse)

SLIDE FOUR

(Arrest record, Drug use, Treatment history)

SLIDE FIVE

(Intoxicants used)

We hypothesized that these adolescents were a heterogenous group. This is how we divided them up. First we identified all of the adolescents who were psychotic at the time of the homicide. Next, we subdivided the nonpsychotic adolescents into two groups: those who committed homicide in the course of another crime, such as a robbery or rape, and those who committed homicide in course of an interpersonal conflict or dispute with the victim. To our surprise, there were very few psychotic adolescents:

SLIDE SIX

(sample size of three homicide groups)

Because of the small number of psychotic cases, I want to concentrate on the crime and conflict groups. First of all, although adolescents

in both groups were charged with murder, the circumstances of their violent behavior were quite different.

SLIDE SEVEN

(Victim relationship)

SLIDE EIGHT

(Accomplice involved)

SLIDE NINE

(Weapon used)

SLIDE TEN

(Intoxication)

What is more important than that these adolescents differ in the kinds of homicides they committed is that there are developmental differences as well. We were interested in assessing what kinds of adjustment problems these adolescents had prior to the homicide. We had coders blind to any information about the offense review clinical records on each adolescent and assess their adjustment in 8 different areas using a total of 52 different variables. I will just summarize the 8 categories we used.

SLIDE ELEVEN

(Prior adjustment categories)

Of these 8 categories, 4 signficantly distinguished the two groups.

SLIDE TWELVE

(Differences between conflict and crime groups)

About half of the adolescents completed the MMPI in the course of their pre-trial evaluation. We compared these adolescents with a

group of adolescents charged with non-violent offenses - auto theft or breaking and entering which did not involve violence against a person.

SLIDE THIRTEEN

(MMPI profile differences of homicide and larceny groups)

As you can see, there were no differences between the two groups in their MMPI profiles. However, once again, it is important to distinguish between different types of violent adolescents. When we subdivided the homicide cases into crime and conflict groups, signficant differences did emerge.

SLIDE FOURTEEN

(MMPI profiles of crime and conflict groups)

Summary

What do these results tell us about assessing violent adolescents? First, only a small minority of the cases were psychotic. Second, there are important differences in the backgrounds of nonpsychotic, violent adolescents. One group commits violent acts in the course of other criminal activity. These adolescents have a history of juvenile delinquency which includes extensive school problems, law-breaking, and substance abuse. Their violent behavior seems to be part of a chronic problem.

In contrast, another group of adolescents commit violent acts in reaction to interpersonal conflict. Although some of them may have prior adjustment problems, a number of them are relatively well-adjusted in comparison to the crime group cases. They tend not to have school and community adjustment problems, although they appear

to be experiencing more environmental stress at the time of their violent behavior.

These differences suggest one reason why clinicians and researchers have not been able to do very well in predicting violent behavior. Violent adolescents are a diverse group and there may be multiple developmental pathways to violent behavior. By identifying different patterns of violent behavior we may be able to improve our clinical predictions.

Issues in Assessing Potentially Violent Adolescents

There are a number of important issues to cover in assessing a potentially violent adolescent. While each evaluation must be adapted to the particular circumstances and needs of the individual case, I want to review some topics you might consider.

1) First, you should always begin these evaluations by reviewing the purpose for the assessment. The adolescent needs to know why he is being evaluated and how the information might be used. The adolescent has a right to know if he is putting himself in legal jeopardy by talking to you.

The issue of confidentiality is crucial. You may have a duty to warn potential victims or take some kind of protective action. I always clarify that there are limits to confidentiality. I explain that I intend to keep the information confidential, but that I would make an exception if I thought he or someone else were in danger.

Some of you may be concerned that the adolescent may be unwilling to talk after you give this kind of warning. This is possible, but in my experience it is more often the opposite. Usually

the youth appreciates being told openly what the evaluation is about, and he may be just as concerned about his potential for violence as you are. (In most cases, the youth is a "he" rather than a "she.")

2) I focus on any recent violent behavior. I insist on reviewing what happened point by point. Often adolescents will minimize what happened or skip over it. I emphasize that I want to understand what happened and why, not that I want to find out what he did that was wrong. I may go over the event several times.

In reviewing what happened, you accomplish several goals. You find out what kind of violent behavior took place, and what it took to provoke the adolescent. Were drugs involved? Was the violence directed at a special person the youth is in conflict with? Is there some topic or issue that really provokes the adolescent?

Also, you begin to assess how well the adolescent can reflect on his own actions and motives. Does he feel remorse and concern for what happened? This may be a way to establish an alliance with him to work on preventing future violence. Are there distortions in how he perceived others? Did he over-react to the situation or misunderstand what was happening? This may be an area for counseling.

You want to find out about other violent incidents as well. Does the youth have chronic self-control problems? Does he use violence as a coping strategy when he is frustrated or was it an isolated incident? This is very important in assessing how likely he is to be violent in the future. Promises and resolutions carry very little weight if there is a pattern of violent behavior.

3) Be sure and assess situational factors. How unusual or how

recurrent is the situation? For example, if a youth gets into fights with his alcoholic father every weekend when the man comes home drunk, it's not hard to predict that it will happen again. If the fighting occurs at school, what are the situational factors involved?

4) Plan your course of action and discuss it with the adolescent. If you are concerned that he will lose control again, let him know. Consider initiating a contract around violent behavior, much like a contract you might negotiate with a suicidal adolescent. Target what the factors are that might provoke him to violence, and decide what he might do if he starts to feel violent again. Discuss alternatives to violence. Find out if he has access to weapons.

5) Finally, you may need to take some action after the evaluation. You have a duty to warn potential victims if you think they are in danger. One suggestion that I have is that if you are uncertain about your evaluation, consult with a colleague. There are two reasons for this. One is that you may have overlooked something and it's good to get a second opinion.

Another reason is that consultation demonstrates professional responsibility and appropriate concern. If an adolescent does become violent in the future, and you are accused of being responsible or negligent in any way, the fact that you consulted with another professional is usually taken as evidence that you used reasonable judgement and attempted to meet the standard of care for your profession. The courts do not require that you are always correct in your judgement, only that you meet the ordinary standards of your profession, whatever they may be.

REFERENCES

Cornell, D., Benedek, E., & Benedek, D. (1987). Juvenile homicide: Prior adjustment and a proposed typology. American Journal of Orthopsychiatry, 57, 383-393.

Keith, C.R. (1984). The aggressive adolescent. New York: Free Press.

McNiel, D.E., & Binder, R.L. (in press). Predictive validity of judgements of dangerousness in emergency civil commitment. American Journal of Psychiatry.

Meehl, P. (1973). Psychodiagnostics: Selected papers. New York: Norton.

Monahan, J. (1981). Predicting violent behavior. New York: Sage.

Moskowitz, D.S., Schwartzman, A.E.,& Ledingham, J.E. (1985). Stability and change in aggression and withdrawal in middle childhood and early adolescence. Journal of Abnormal Psychology, 94, 30-41.

Olweus, Dan. (1979). Stability of aggressive reaction patterns in males: A review. Psychological Bulletin, 86, 852-875.

Steadman, H.J. & Halfon, A. (1971). The Baxstrom patients: Background and outcomes. American Journal of Psychiatry, 3, 376-385.

Wenk, E. (1972). Can violence be predicted? Crime and Delinquency, 18, 393-402.

MODIFIED SUMMARY OF SLIDES 3-5

	Homicide charge (n=72)	Nonviolent larceny charge (n=35)	Significance test
Prior arrests			$\chi^2 = 11.74$, $p < .01$
None	31 (43%)	7 (20%)	
One	15 (21%)	4 (11%)	
Two	12 (17%)	7 (20%)	
Three or more	14 (19%)	17 (49%)	
Prior juvenile placements			Fisher exact test
No	52 (72%)	18 (51%)	$p = .03$
Yes	20 (28%)	17 (49%)	
Alcohol abuse			$\chi^2 = 1.87$, ns
No occasional drinking	19 (26%)	7 (20%)	
Occasional drinking	29 (40%)	19 (54%)	
Regular/heavy drinking	24 (33%)	9 (26%)	
Other drug abuse			$\chi^2 = .31$, ns
No occasional drug use	15 (21%)	7 (20%)	
Occasional drug use	28 (39%)	12 (34%)	
Regular/heavy drug use	29 (40%)	16 (46%)	
Age at offense			
15 or under	13 (18%)	1 (3%)	
16	10 (14%)	2 (6%)	
17	27 (38%)	19 (54%)	
18	22 (31%)	13 (37%)	
Mean (S.D.)	16.7 (1.28)	17.3 (.71)	$t = 2.31$, $p < .05$
Race			Fisher exact test
White	39 (54%)	26 (74%)	$p = .04$
Non-white	33 (46%)	9 (26%)	
Parent marital status			$\chi^2 = .85$, ns
Married	18 (25%)	6 (17%)	
Divorced	46 (64%)	25 (71%)	
Never married	8 (11%)	4 (11%)	
High school status			Fisher exact test
Enrolled/graduated	37 (51%)	12 (34%)	$p = .07$
Drop-out/expelled	35 (49%)	23 (66%)	
Mental health treatment			
Outpatient treatment			Fisher exact test
Yes	16 (22)	19 (54%)	$p = .001$
No	56 (78%)	16 (46%)	
Inpatient treatment			Fisher exact test
Yes	11 (15%)	15 (43%)	$p = .002$
No	61 (85%)	20 (57%)	
Medication used			Fisher exact test
Yes	8 (11%)	11 (31%)	$p = .01$
No	64 (89%)	24 (69%)	

SLIDE SIX

ADOLESCENT HOMICIDE GROUPS

Psychotic at offense	5	(7%)
Crime-related offense	37	(51%)
Conflict-related offense	30	(42%)

SUMMARY OF SLIDES 7-10

Victim Relationship	Crime Group (n=37)	Conflict Group (n=30)	Psychotic Group (n=5)*
Family member	1 (3%)	13 (43%)	1
Familiar person	15 (41%)	15 (50%)	2
Stranger	21 (57%)	2 (07%)	2
Weapon Used			
None	13 (35%)	2 (07%)	1
Gun	9 (24%)	14 (47%)	1
Knife	7 (19%)	8 (27%)	3
Club/other	8 (22%)	6 (20%)	0
Intoxication			
Alcohol/Drugs	27 (73%)**	9 (30%)	2
None reported	9 (24%)	21 (70%)	3
Accomplice Present			
Yes	21 (57%)	4 (13%)	0
No	16 (43%)	26 (87%)	5
Post-Homicide Behavior			
Fled scene	36 (97%)	19 (63%)	3
Arrested at scene	1 (03%)	11 (37%)	2

Note: *Due to small sample size, percentages not presented.
**In one case, information missing on question of intoxication.

SLIDE ELEVEN

PRIOR ADJUSTMENT CATEGORIES

Family dysfunction	School problems
Childhood symptoms	Criminal activity
Prior violence	Substance abuse
Psychiatric history	Stressful life events

SLIDE TWELVE

PRIOR ADJUSTMENT OF CRIME AND CONFLICT GROUPS

COMPOSITE CATEGORY	SELECTED ITEMS
	Crime group more likely to have...
School Problems***	Dropped-out of school
	Failed a grade or have failing grades
	Been truant from school
Substance Abuse*	Alcohol abuse
	Drug abuse
	Started use in early or pre-teens
Criminal Activity*	Committed Breaking and Entering
	Been placed in a juvenile facility
Stressful Events***	Fewer recent stressful events

* $p < .05$ *** $p < .001$